South Carolina HIV Planning Council

MEMBERSHIP APPLICATION

All information provided in this application will be kept <u>CONFIDENTIAL</u>.

(Please print legibly or type)

South Carolina HIV Planning Council
MEMBERSHIP APPLICATION

Name: _____

Date of Birth (month/day/year): _____

HOME CONTACT INFORMATION

Home Address: _____

City, State, Zip Code: _____

County of Residence: _____

Home Telephone Number: ( )

Alternate Phone (cell/other): ( )

Home Fax Number: ( )

Home E-mail Address: _____

WORK CONTACT INFORMATION
❑ **NOT APPLICABLE**

Agency/Organization: _____

Address: _____

City, State, Zip Code _____

Counties served: _____

_____

Work Telephone Number: ( )

Work Fax Number: ( )

Work E-mail Address: _____

Person to Contact in Case of Emergency:

Name: _____

Phone Numbers: _____

Education:

Name and Location of School	Highest Education Level Achieved (Diploma, Certificate, Degree)	Major/Minor
Example: Eau Claire HS Columbia, SC	Diploma	Not Applicable (NA)

I. GENDER (Select one):

- ❑ Female
- ❑ Male
- ❑ Transgender

II. ETHNICITY (Select one):

- ❑ Hispanic/Latino
- ❑ Non-Hispanic/Latino

III. RACE (Select one):

- ❑ Asian/Pacific Islander
- ❑ Black
- ❑ Native American/Alaska Native
- ❑ White
- ❑ Other (Please specify):_____

IV. REPRESENTATION OF HIV EXPOSURE and STATUS: (Optional)

If you choose not to divulge the categories of HIV Exposure or HIV Status, you cannot be chosen as a representative of that population.

A. HIV Exposure (Select all that apply):

- ❑ Man who has Sex with Men
- ❑ Man who has Sex with Men/Injecting Drug User
- ❑ Injecting Drug User
- ❑ Mother With/At Risk for HIV Infection
- ❑ Other (please specify): _____
- ❑ Unknown

B. HIV Status (Select one):

- ❑ Positive
- ❑ Negative
- ❑ Unknown

VI. Preferred Choice of Subcommittee

From the four standing subcommittees of the HIV Planning Council with open membership, please rank order your choice of committees on which you wish to serve (1 being most desired, 4 being least desired):

_____ Care and Support Services
_____ Consumer Advisory
_____ Needs Assessment
_____ Prevention

VII. Skills and Experience

From the list of HIV-related services listed below, please check all that you have experience in providing.

____ Advocacy
____ Case Management
____ Clinical Care
____ Counseling and Testing
____ Health Education/Risk Reduction
____ Housing
____ Mental Health Services
____ Outreach
____ Partner Notification
____ Substance Abuse Services
____ Other (please specify: _____

_____

QUESTIONS

1. Briefly describe your involvement working with HIV prevention and/or care in your local community. If you are a paid staff member of an organization involved in HIV/STD prevention and/or care, please include a copy of your resume or curriculum vita (CV).

2. Why are you seeking membership on the SC HIV Planning Council? What do you have to offer as a member of the Planning Council?

3. What boards, task forces, and other planning or community groups do you serve on or represent?

4. Please provide the contact information for three (3) people who can affirm the information you have provided.

   Name # 1_____

   Title: _____

   Agency/Organization: _____

   Mailing Address: _____

   _____

   Phone Number: _____

   Name # 2 _____

   Title: _____

   Agency/Organization: _____

   Mailing Address: _____

   _____

   Phone Number: _____

   Name # 3_____

   Title: _____

   Agency/Organization: _____

   Mailing Address: _____

   _____

   Phone Number: _____

_____ (initial) I have received the commitment requirements and responsibilities for the SC HIV Planning Council and am able to fulfill these requirements and responsibilities if I am selected.

I understand, affirm, and agree that all statements on this form are true and accurate; any misrepresentation or omission or facts may result in my being disqualified for membership on the SC HIV Planning Council.

_____

Signature Date

Signature of Parent/Guardian if under 18 years of age: _____